Health Law Developments

The Newsletter of the Health Law Section
State Bar of Georgia
Fall 2016

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From the Chair

by Dan Mohan

Dear Section Members:

The Executive Committee of the Health Law Section of the State Bar of Georgia is pleased to present you with the Section's Fall 2016 Newsletter. Many thanks to Executive Committee member Lynnette Rhodes for her efforts in editing and publishing this Newsletter.

The Health Law Section had a busy year. As a section we sponsored or co-sponsored two ICLE seminars, produced two "Lunch and Learn" presentations which were simulcast via audio feed to Section members who were unable to attend in person, and hosted our first after-hours social function in June. In addition, the Section awarded $1,000 scholarships to outstanding third year health law students at the University of Georgia School of Law, Emory University Law School, Georgia State University Law School, and Mercer University Law School.

The State Bar took note of the Section's activities, awarding the Health Law Section its 2015-2016 Section Award of Achievement!

On a terribly sad note, however, the Health Law Section and Georgia Bar lost one of our most beloved members this year. Alan Rumph passed away on Feb. 21, 2016, after a long battle with cancer. Alan was one of the finest health law attorneys in the U.S., specializing in Stark, Anti-Kickback Statute and False Claims Act compliance. More importantly, Alan was one of the finest people ever to have served on the Executive Committee. He was a great friend, counselor and colleague, and he will be sorely missed. In honor of Alan, each of the law school scholarships referenced above will henceforth be known as the "Alan Rumph Memorial Scholarship."

The Advanced Health Law Seminar will be held on Sept. 30, at the Four Seasons Hotel in Midtown Atlanta. We look forward to seeing you there.

Best regards,

Dan Mohan

The Georgia ABLE Program

by William H. Overman, CAP[1]

On Dec. 19, 2014, President Obama signed into law The Stephen Beck Jr., Achieving a Better Life Experience Act of 2014[2], better known as the ABLE Act. The Act is intended to promote the independence of persons with disabilities by allowing them to have an ABLE Act savings account in their own name, from which they would make payments for certain disability-related expenses. The Act parallels the legislation that created 529 Education Accounts. As part of the need to keep the ABLE Act revenue neutral, Congress enacted it as tax legislation rather than benefits legislation. The ABLE Act is incorporated as §529A of the Internal Revenue Code (IRC). Of note, however, is that although the ABLE Act is part of the IRC, both the IRS and the SSA are charged with promulgating enabling regulations.

Key points regarding the ABLE Act and ABLE Plan accounts:

- The original thought and intent behind the push for ABLE Accounts, within the disability advocacy community, was that ABLE Accounts would serve two main purposes: To give the person with disabilities a feeling of independence; and, to serve as an alternative to the expense and complexity of setting up and administering a Special Needs Trust.
- To keep the ABLE Act revenue neutral, Congress established strict financial limits on the accounts. As a result, the accounts in reality will not be a useful alternative to Special Needs Trusts.
- Total contributions in a year are limited to the gift tax exclusion amount ($14,000 in 2016).
- Total contributions over time are limited: For state ABLE Plans the total contribution limit is the same as the limit for the state's 529 Plan ($235,000 in Georgia); for SSI the limit for retaining SSI cash benefits (*i.e.*, monthly SSI payment) is $100,000 – although exceeding this SSI limit will not affect the account beneficiary's Medicaid eligibility.
- The Act authorizes but does not require states to set up ABLE Plans. Any state desiring to establish an ABLE Plan needs to do so through state legislation.
- If a given state decides not to set up its own ABLE Plan, it can contract with another state that has established its own Plan to be used by its residents. For example, Ohio, Nebraska and Tennessee have established ABLE Plans designed and intended to be utilized by beneficiaries nation-wide.
- Only "qualified individuals" may have ABLE accounts, with "qualified" generally meaning that the individual is blind or disabled as defined for SS purposes, and the blindness or disability arose prior to their twenty-sixth birthday.
- A rollover of an ABLE account to a family member who is also disabled is permitted.
- Contributions can only be made by "family members" as that term is defined in the federal Act.
- Contributions must be "cash" (presumably meant to exclude in-kind stock transfers, but not to include checks).
- Although ABLE accounts have been promoted as "tax free," that is not correct – they are tax deferred.
- There is no income tax benefit on contributions to an ABLE account, but growth in the ABLE account is untaxed.
- Withdrawals from an ABLE account are tax-free if made for "qualified disability expenses" as defined in the federal Act. The Act provides an initial laundry list, to which the IRS can supplement by regulation. The list includes the following::
    - Education;
    - Housing;
    - Transportation;
    - Employment training and support;
    - Assistive technology and related services;
    - Health;
    - Prevention and wellness;
    - Financial management and administrative services;
    - Legal fees;
    - Expenses for ABLE account oversight and monitoring;
    - Funeral and burial; and,
    - Basic living expenses.
- Qualified disability expenses may be reimbursed from the ABLE account - including to the beneficiary.
- There is a ten percent surtax on distributions for other than qualified disability expenses, and the distribution(s) will be included in the beneficiary's taxable income.
- If a non-qualified expense is paid from the ABLE account, the ABLE account is no longer exempt from consideration by SSI and Medicaid.
- There is a significant "kicker" to ABLE accounts that has not been widely publicized – a Medicaid Payback provision pursuant to which a state Medicaid plan "may" file a claim against the ABLE

account upon the death of the account beneficiary (§529A(f)).

ABLE in Georgia

In response to the efforts of various advocates and advocacy organizations for persons with disabilities, in January, 2016, House Bill 710 was introduced during the Georgia Legislative Session. H.B. 710 proposed the addition of a new chapter to Title Thirty of the Official Code of Georgia Annotated, to be known as the "Georgia Achieving a Better Life Experience (ABLE) Act." Following review and discussion, H.B. 710 was replaced by H.B. 768[3], which included revisions expanding and clarifying the administration of the program and significantly tightening the privacy of information provisions. House Bill 768 was passed by the Georgia General Assembly, signed into law by the Governor on May 3, 2016, and became effective July 1, 2016.[4]

Things to know about the Georgia ABLE Act:

- "It is the intent of the legislature to establish a qualified ABLE program in this state which will encourage and assist the saving of private funds in tax-exempt accounts in order to pay for the qualified disability expenses of eligible individuals with disabilities. It is also the intent of the legislature that the qualified ABLE program be implemented in a manner that is consistent with federal law authorizing the program and that maximizes program efficiency and effectiveness."[5]
- Administration of the Act is vested in a new state instrumentality, the Georgia ABLE Program Corporation.[6] This Corporation is subject to the provisions of the Georgia Administrative Procedure Act, O.C.G.A. § 50-13-2, by virtue of being added to the definition of a state "Agency" set forth in this Code section.
- The Board of the Corporation consists of the Governor as Chairperson; the Commissioner of the Department of Behavioral Health and Developmental Disabilities; the Commissioner of the Department of Community Health; the State Auditor; the Director of the Office of Planning and Budget; the State Revenue Commissioner; the State Treasurer; and three Directors appointed by the Governor. These three Directors will serve at the pleasure of the Governor, and will include at least two persons who are persons with a disability, a family member of a person with a disability, or a disability advocacy professional. In addition, the State Treasurer will act as Administrative Officer of the Board.
- The Board is granted specific authorities necessary "or convenient" to carry out the purposes and objectives of the Program[7], as well as the authority to establish an investment plan for the Program.[8]
- The finances of the Program will be handled by way of the Georgia ABLE Program Trust Fund, specified as being a separate fund in the state treasury.[9]
- Upon the death of the Designated Beneficiary of an ABLE account, the Department of Community Health and the Medicaid program of another state may file a claim with the Georgia ABLE Program for the total amount of medical assistance provided for the designated beneficiary under the Medicaid program after the date of the establishment of the ABLE account, less any premiums paid by or on behalf of the designated beneficiary to a Medicaid buy-in program.[10]
- The Act includes several "safety valve" provisions:
  - "The Georgia ABLE Program shall continue in

existence until terminated by law. If the state determines that the program is financially infeasible, the state may terminate the program. Upon termination, amounts in the trust fund held for each designated beneficiary shall be returned in accordance with the participation agreement.[11]

- "Material misrepresentations by a party to the participation agreement, other than the Georgia ABLE Program Corporation, in the application for the participation agreement or in any communication with the Georgia ABLE Program Corporation regarding the Georgia ABLE Program may result in the involuntary liquidation of the ABLE account. If an account is involuntarily liquidated, the designated beneficiary is entitled to a refund, subject to any fees or penalties provided by the participation agreement and the Internal Revenue Code."[12]

- ABLE accounts, whether with the Georgia ABLE Program or the ABLE Program of another state, are excluded from consideration in determining financial eligibility, including earnings and distributions for qualified disability expenses.[13]

Conclusion – win-win?

At this point in time some thirty-six states have passed legislation authorizing the establishment of ABLE Programs, with more on the way. One of the primary considerations in the original push for the federal ABLE legislation was that ABLE accounts would serve as an alternative to the time, cost and effort of establishing and administering Special Needs Trusts. However, given the financial limitations placed on ALBE accounts by the federal Act, ABLE accounts are not really an alternative to Special Needs Trusts. Rather, they are something that can be included in the financial planning for a person with disabilities in addition to a Special Needs Trust. In this sense ABLE accounts represent a win-win situation. Will ABLE accounts be effective in helping to meet the financial and personal needs of persons with disability? Hopefully, yes.

(Endnotes)

1 William ("Bill") Overman serves as the Director of Trust Services with HMS. He can be reached via email at woverman@hms.com. The views expressed in this article are his own and not those of HMS, or its officers, employees, or customers.
2 *The Stephen Beck Jr., Achieving a Better Life Experience Act of 2014*, Pub. L. No. 113-295, 128 Stat. 4010.
3 Georgia Achieving A Better Experience (ABLE) Act; H.B. 768, 153rd General Assembly, 2015-2016 Regular Session.
4 *Id.*
5 O.C.G.A. § 30-9-2.
6 O.C.G.A. § 30-9-4.
7 O.C.G.A. § 30-9-4(b).
8 O.C.G.A. § 30-9-10.
9 O.C.G.A. § 30-9-8.
10 O.C.G.A. § 30-9-14.
11 O.C.G.A. § 30-9-5(b).
12 O.C.G.A. § 30-9-7(a)(6)
13 O.C.G.A. § 30-9-11

Georgia Legislature Compels Testing of Backlogged Rape Kits. Issues Remain

by Professor Elizabeth Weeks Leonard; J. Alton Hosch Professor of Law, University of Georgia School of Law; Morgan Melodie Johnson, University of Georgia, J.D. expected 2017

On April 26, 2016, Gov. Nathan Deal signed into law, S.B. 304/H.B. 827, known as the Pursuing Justice for Rape Victims Act. The Georgia Senate unanimously passed the measure during the 2016 legislative session, despite last-ditch efforts by Sen. Renee Unterman (R) to block the bill. The law aims to set standards for rape evidence collection and compels law enforcement testing of both backlogged and newly gathered rape kits within certain time frames. Despite this salutary policy, much DNA evidence of alleged sexual assaults remains difficult to gather.

Background:

In the summer of 2015, the Atlanta Journal-Constitution (AJC) ran an exposé uncovering a massive backlog of forensic evidence that had been collected from rape victims which the hospital had failed to hand over to law enforcement officials.[1] Instead of this valuable DNA evidence (rape kits include samples of bodily fluids, hair, and other DNA samples collected from victims) being tested, it remained locked away in basement storage. Grady's approximately 1,500 untested kits included at least 136 rape kits that the victims specifically requested, in writing, be submitted to the police. On top of the backlog, AJC investigations also revealed that Grady had improperly billed more than 730 rape victims for performing forensic exams even though the service should be paid for by a special state fund.[2] Grady's incompetence in handling rape cases is particularly disturbing as Grady is the only rape crisis center that is servicing Fulton County's approximately one million residents, so there are no other options for victims in Fulton County to turn to when seeking help after a sexual assault.[3]

Grady Hospital defended the backlog under the mistaken belief that federal privacy regulations prevented them from handing this evidence over to the police. One of their attorneys spoke with the AJC on the hospital's position, stating, "Our interpretation of the law is we cannot—will not—give out medical information to law enforcement when a patient expressly asks us not to, absent a court order."[4] Eventually however, Grady yielded to public outcry and began to transfer the kits to the Georgia Bureau of Investigations (GBI).[5] This highlighted even further problems with the functioning of the justice system because the GBI did not have the funds to test all the kits; although the kits were now in law enforcement's hands, the evidence still remained untested.[6]

After the Grady scandal, it came to light that there were similar rape kit backlogs in other Georgia counties. In Clarke County, it was determined that at least 159 rape kits dating back to the 1990s had not been tested. In Cobb County, police found at least 365 untested kits, including some dating back to the 1970s.[7] It is clear that action needed to be taken within the system to ensure proper and prompt processing of this evidence to ensure the effective administration of justice.

Since the rape kit backlog has been exposed, Georgia has received $2 million in federal funding to aid in the effort to sort through and test the forensic evidence. The federal government has committed a total of $79 million to 20 states that have issues with backlogged rape kits.[8]

Existing Law:

Prior to the passage of S.B. 304, an under-enforced and under-recognized Georgia law, O.C.G.A. § 31-7-9, required medical facilities, including hospitals, to report to law enforcement "non-accidental injuries to patients."[9] The statute requires an oral report to be made immediately by telephone to be followed by a more formal written report.[10] The statute requires the report to contain the name and address of the patient, extent of the patient's injuries, and any other information that the reporting person believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator.[11] This law is not in conflict with federal privacy law, including the Health Insurance Portability and Accountability Act, which expressly allows disclosures of personal health information to law enforcement, as required by state law.[12] Because non-accidental injuries are required to be reported to police, it follows that these reports should be made in instances when a rape victim comes to a hospital for treatment. Such reporting is sound policy because that information may be critical in establishing the cause of injury and identifying the perpetrator.

It turns out there was confusion all around on this issue. Not only were hospitals unsure whether and when they should report crimes and turn over evidence, GBI officials said when the testing program of rape kits began some 20 years ago, it restricted analysis to cases where there was an identified suspect.[13] Though state policy had changed, it seemed some local agencies were still operating under this dated policy. Accordingly, if there was no suspect in sight, police did not hand over the evidence to be tested.[14]

Controversy:

Because of the controversy that erupted around the Grady backlog, Rep. Scott Holcomb of Atlanta proposed a bill, titled "Pursuing Justice for Rape Victims Act," during the most recent legislative session.[15] Holcomb emphasized the urgency of the bill stating, "we are facing an epidemic nationally and here in Georgia of rape kits not being processed in a timely manner."[16] The bill passed

unanimously in the House but met opposition when it reached the senate.[17] Sen. Renee Unterman who chairs the Health and Human Services Committee blocked the bill.[18] Unterman opposed the bill because she believed the problem was endemic only to Atlanta and did not affect the rest of Georgia (a fact contradicted by the findings of backlogs in many other counties in Georgia—even in Unterman's home county of Gwinnett).[19] She did hold a committee hearing on sexual assault on college campuses. During the hearing, Unterman indicated that she spoke with law enforcement about the issue of the backlog and gleaned that no further action was needed on the part of the legislature.[20] She faced backlash from victim's rights advocates and sexual assault survivors.[21] Eventually she relented and voted for the bill, which passed in the session's final minutes before midnight.[22] The Senate added a few changes to the original bill so it had to go back to the house for a final vote before it officially passed.

New Requirements:

The bill itself requires that hospital staff pass over rape kits to law enforcement within 96 hours of being collected.[23] The new requirement applies only to rape kits collected in cases in which the victim has requested intervention from law enforcement.[24] Once law enforcement takes possession of the rape kit, they have 30 days to hand it over to the Division of Forensic Sciences of the GBI.[25] The law also addresses the issue of rape kits gathered prior to the passage of this legislation and provides a schedule for how and when those are to be dealt with—all of these kits must be submitted to GBI forensics by Aug. 31, 2016.[26] Furthermore, the law requires that the Division publish annual statistics showing how many kits have been tested each year so that the public can hold the state accountable.[27] The bill did not allocate any funds to be spent on ensuring the testing of these rape kits. But, as noted above, Georgia has received $2 million in federal funding for this purpose.

Remaining Problems:

Despite those laudable changes, issues remain for rape kits gathered from victims who either declined to have law enforcement involved, or who did not specify a preference regarding law enforcement involvement. The pre-existing Georgia law, O.C.G.A. § 31-7-9, which mandates reporting in the case of non-accidental injury would seem to require that all rapes should be reported, regardless of the wishes of the victim. But health care providers apparently were not interpreting that law to include rape victims. The new law also does not definitively answer that question as it imposes the four day requirement only in instances where the victim has requested the involvement of law enforcement. Obviously, this is a sensitive issue and some would argue health care providers and law enforcement should defer to the victims' wishes in deciding whether to pursue legal action. Such deference is not given to victims of other crimes, such as assault, battery, domestic violence (not involving rape), even if it is against their wishes to involve law enforcement. Testing rape kits even in cases where the victim does not wish to press charges may help identify serial rapists when the DNA evidence is entered into a larger database, and, therefore, help prevent further crime. Despite the new non-accidental reporting requirements, this remains a grey area of the law. It is unclear what will happen to rape kits when the victim does not positively assert that he or she wants to involve law enforcement.

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Federal Health Care Fraud Initiatives - Year in Review

by Emma R. Cecil and Brian F. McEvoy

Over the last several years, the Department of Justice has made no secret about its enhanced focus on detecting and prosecuting health care fraud and abuse. Indeed, the significant leverage wielded by the government continues to escalate as a result of the proliferation of whistleblower-driven parallel civil and criminal investigations; the government's increasingly aggressive use of the "implied certification" doctrine, statistical sampling, and other novel theories of liability; and the more frequent criminalization of what were once considered routine transactions and business arrangements.

In her Sept. 17, 201,4 remarks before an audience at the Taxpayers Against Fraud Education Fund Conference, Leslie Caldwell, Assistant Attorney General for the Criminal Division of the Department of Justice (DOJ), announced that the DOJ was "stepping up" its use of the False Claims Act (FCA) to investigate and prosecute fraud involving government programs through the formal adoption of a new policy under which all qui tam complaints are to be shared by the Civil Division with the Criminal Division as soon as the cases are filed.[1] While the Criminal Division previously had the discretion to review FCA cases, Main Justice prosecutors are now required to conduct an immediate review of each and every civil qui tam complaint to determine whether to open a parallel criminal investigation. Mandatory early coordination between DOJ's civil and criminal divisions means that criminal investigators are now coming in on the ground floor of whistleblower cases, bringing with them the full panoply of evidence-gathering tools, including search warrants, wiretaps, and undercover operations, that are unavailable to their civil counterparts.

Although the policy covers all qui tam complaints, AAG Caldwell warned that those alleging fraud against government health care programs would receive particular scrutiny. For example, while cases involving excessive physician compensation historically have been brought as civil suits alleging violations of the Stark Law, AAG Caldwell's announcement presaged a potential shift toward the policing of physician compensation arrangements through criminal Anti-Kickback prosecutions. If AAG Caldwell's remarks implicitly foretold such an outcome, the June 9, 2015, OIG fraud alert – which cautioned that compensation arrangements may violate the Anti-kickback Statute if even one purpose of the arrangement is to compensate a physician for Medicaid or Medicare referrals and admonished healthcare providers to "carefully consider" compensation arrangements before entering into them – made it explicit that cases once thought to have only civil repercussions are now more likely to lead to criminal sanctions if the government believes it can prove the requisite intent.[2] At the very least, the fraud alert is a strong reminder that the government now has individual physicians, and not only the hospitals and other healthcare organizations that pay them, squarely in its sights.

In short, the stakes have never been higher for FCA defendants, and, given the greater prospect of parallel criminal investigations, the path to resolution of even the most seemingly unremarkable FCA cases has never been more fraught with uncertainty. The increased risk of criminal prosecution as a result of Main Justice's routine and systematic review of civil qui tam complaints is not, of course, limited to corporate healthcare providers. In trumpeting the Criminal Division's "unparalleled experience prosecuting health care fraud" and its ability, unlike that of the Civil Division, to seek, in addition to imprisonment, remedies such as the freezing of assets, AAG Caldwell's remarks heralded a reinvigorated focus on holding individuals – both healthcare providers and executives – personally and criminally accountable for alleged fraud.

Any doubts as to DOJ's commitment to this objective following AAG Caldwell's September 2014 pronouncement were swiftly and soundly dispelled by the Sept. 9, 2015, memorandum from Deputy Attorney General Sally Yates regarding "Individual Accountability for Corporate Wrongdoing."[3] Known as the "Yates Memo," the directive announced a formal policy of combating corporate crime by targeting and seeking accountability from the individuals involved in the wrongdoing. To that end, the Yates Memo outlines six "key steps" for federal prosecutors to follow in order "to most effectively pursue the individuals responsible for corporate wrongs."

First, to be eligible for any cooperation credit, corporations must provide to the Department all relevant facts about the individuals involved in corporate misconduct, regardless of their position, status, or seniority. Second, both criminal and civil attorneys should focus on individual wrongdoing from the very beginning of any investigation of corporate misconduct in order to maximize the chances that any final resolution will include civil or criminal charges against both the corporation and culpable individuals.

Third, criminal and civil DOJ attorneys should be in "routine communication" with one another, including criminal attorneys notifying their civil counterparts "as early as permissible" when conduct giving rise to potential individual civil liability is discovered. Fourth, DOJ should not, absent extraordinary circumstances, agree to any corporate resolution that provides protection

for individuals from criminal or civil liability. Fifth, DOJ should not resolve corporate cases "without a clear plan to resolve related individual cases before the statute of limitations expires." Finally, civil attorneys should consistently focus on individuals and evaluate whether to bring suit against an individual based on considerations beyond that individual's ability to pay.

The most conspicuous feature of the Yates Memo is its principal guideline requiring corporations to give up individuals in order to receive any cooperation credit at all. While focusing on the individuals involved in corporate wrongdoing is not a novel concept – nor is there anything new about considering the extent to which a company cooperates as a factor in mitigation of criminal liability – what makes the Yates Memo noteworthy is that it elevates cooperation against individuals from merely a factor to be considered to a "threshold requirement." This hard line, "all or nothing" approach, under which corporations can no longer avoid indictment by voluntarily disclosing corporate misconduct but stopping short of identifying the individuals involved, represents a substantial departure from previous DOJ policy and presents new challenges for companies under government investigation.

Perhaps most significantly, the requirement that a company deliver up individuals and all evidence against them before it can even be considered for cooperation credit is likely to have a chilling effect on employees' willingness to assist counsel conducting internal investigations. Inasmuch as the government often relies heavily on the results of corporate internal investigations, the memo could have the unintended consequence of making corporate fraud even harder to prove. The memo also neglects to address the very real possibility that a corporation might, after conducting a thorough and painstaking investigation, fail to discover any evidence of individual criminal wrongdoing. Where a company is unable to gather the kind of evidence the government is expecting, the government might wrongly assume the company has been less than diligent or forthcoming, and withhold cooperation credit as a result. One can easily imagine a scenario in which companies might adopt their own all-or-nothing approach, deciding that it isn't worth undertaking a costly, protracted investigation only for DOJ to conclude that the company didn't go quite far enough to clear the cooperation hurdle.

Although it remains to be seen how and to what extent the policies outlined in the Yates Memo will be applied in practice, recent criminal prosecutions of healthcare providers and executives make clear that DOJ is delivering on the promises AAG Caldwell made in her remarks last September. As Attorney General Loretta Lynch and Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell announced in a June 18, 2015, press release, enforcement efforts led by the Medicare Fraud Strike Force have resulted in charges against 243 individuals, including 46 doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $712 million in false billings.[4] According to the HHS-OIG's Semiannual Report to Congress, during the first half of FY 2015, OIG reported 486 criminal actions against individuals or entities that engaged in crimes against HHS programs.

Notable prosecutions include the highly publicized case of Chicago's Sacred Heart Hospital, whose former owner was sentenced on July 29, 2015, to 4 1/2 years in prison for paying massive kickbacks to doctors so that they would in turn refer Medicare patients to the hospital. In other high profile cases out of Michigan and Texas, a Detroit hematologist-oncologist was sentenced on July 10, 2015 to 45 years in prison and ordered to forfeit $17.6 million for prescribing and administering unnecessary and aggressive chemotherapy and other cancer treatments to over 500 patients in order to increase his billings to Medicare, and an assistant hospital administrator in Houston was sentenced in May 2015 to 40 years in prison and ordered to pay restitution in the amount of $31 million for his role in a $116 million Medicare fraud scheme involving the hospital's partial hospitalization program (PHP) services, a form of intensive outpatient treatment for severe mental illness. Ten other individuals pleaded guilty or were convicted for their roles in that scheme, including the hospital's president, the operator of one of the hospital's satellite psychiatric facilities, and the owner of a group home. They were sentenced in June 2015 to 45, 20, and 12 year terms, respectively, and ordered to pay restitution in the amounts of $46,753,180, $7,518,480, and $46,255,893, respectively. A patient recruiter who was also convicted of conspiracy to pay and receive kickbacks is scheduled to be sentenced in December 2015.

Civil recoveries have been equally impressive. In FY 2014, the government recovered $3.3 billion from individuals and companies accused of defrauding federal health programs, $2.3 billion of which was recovered through settlements and judgments in FCA cases involving false claims submitted to Medicare and Medicaid.[5] In the first six months of FY 2015 alone, OIG recovered $1.8 billion from healthcare providers and programs, and reported 326 civil actions – including false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties settlements, and administrative recoveries related to provider self-disclosure matters – and the exclusion of 1,735 individuals and entities from participation in Federal health care programs.

Notable cases on the civil side include the July 2, 2015, affirmation by the Fourth Circuit of a $237 million FCA judgment against Tuomey Healthcare System, Inc. as a result of its violations of the Stark Law; a $69.5 million settlement entered into by North Broward Hospital District on September 15, 2015 to resolve allegations that it engaged in improper financial relationships with referring physicians; and an $18.8 million settlement entered into by Westchester Medical Center in May 2015 resolving allegations that it improperly compensated a cardiology practice located on its campus. These cases highlight the government's increasing use of the FCA to enforce the Stark Law and monitor financial relationships between

hospitals and providers. Given the progressively large recoveries the government has secured in these cases, one can expect the uptick in FCA qui tam lawsuits alleging Stark violations to continue.

The shifting landscape of health care fraud enforcement, and the government's tenacious pursuit of individuals and corporations through parallel civil and criminal proceedings, makes it more critical than ever for providers and their counsel to be as vigilant as possible in anticipating and guarding against compliance risks. Health care providers and organizations should strive to mitigate these risks by routinely and rigorously reviewing and strengthening their compliance efforts, and adapting those efforts to the ever changing regulatory and enforcement environments.

(Endnotes)

1 http://www.justice.gov/opa/speech/remarks-assistant-attorney-general-criminal-division-leslie-r-caldwell-taxpayers-against

2 http://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf

3 http://www.justice.gov/dag/file/769036/download

4 http://www.justice.gov/opa/pr/national-medicare-fraud-takedown-results-charges-against-243-individuals-approximately-712

5 According to the Annual Report of the Departments of Health and Human Services and Justice, DOJ opened 924 new criminal health care fraud investigations in FY2014. Federal prosecutors filed criminal charges in 496 cases involving 805 defendants, and a total of 734 defendants were convicted of health care fraud-related crimes during the year. DOJ also opened 782 new civil health care fraud investigations and had 957 civil health care fraud matters pending at the end of the fiscal year. HHS-OIG investigations resulted in 867 criminal actions against individuals or entities that engaged in crimes related to Medicare and Medicaid, and 529 civil actions, and the exclusion of 4,017 individuals and entities from participation in Medicare, Medicaid, and other federal health care programs. Among these were exclusions based on criminal convictions for crimes related to Medicare and Medicaid (1,310) or to other health care programs (432), for patient abuse or neglect (189), and as a result of licensure revocations (1,744).
See http://oig.hhs.gov/publications/docs/hcfac/FY2014-hcfac.pdf.

Closing the Coverage Gap: Georgia's Path to Medicaid Expansion

by Jeff Rowe[1]

Background

Since the passage of the Affordable Care Act (ACA or Obamacare) in 2010, nearly three million poor Americans still lack health insurance. These individuals fall within the "coverage gap" resulting from state decisions not to accept federal Medicaid dollars.[2] Currently, approximately, 89 percent of this uninsured population resides in the South, and 11 percent – roughly 650,000 people – reside in the state of Georgia.[3] Although some lawmakers complain that the cost of expanding Medicaid in Georgia is too expensive, state health policy experts and medical professionals argue that refusing to expand Medicaid not only results in a net loss of billions of dollars in federal funding; doing so will continue to exacerbate existing dire hardships for Georgia residents and hospitals alike.[4]

As demonstrated in Arkansas and Louisiana, expanding Medicaid is not only politically and economically feasible, but doing so would likely increase state revenue in southern states and decrease uncompensated care costs. In fact, as recently as December 2015, Virginia[5] and Alabama[6] have pushed for Medicaid expansion, despite political opposition; and, although Gov. Deal and Republicans in the Georgia legislature remain opposed to Medicaid expansion in Georgia,[7] low-income residents and hospitals alike would benefit from unlocking billions in federal dollars that could be used to develop a "Georgia-specific solution."

The Arguments For and Against Medicaid Expansion

In Georgia, the most commonly stated argument against accepting federal funds for Medicaid expansion is cost. Specifically, the argument is that Georgia cannot afford to expand an already over-stretched program.[8] Gov. Deal has repeatedly stated that expanding such a program would cost the state approximately $4 billion over ten years.[9] This oft-repeated argument that expansion would cost too much is not unique to Georgia. This has been the chief argument of opposition states across the board.[10] Yet, even if Governor Deal's estimates are accurate, and Medicaid expansion were to cost Georgia $4 billion over the next decade, health policy experts have predicted that failing to expand Medicaid will have even greater economic consequences. For example, the projected loss of $33.7 billion in federal funding for the state, and the projected loss of $12.8 billion in reimbursement for hospitals through the year 2022.[11] Moreover, experts suggest that the actual state cost to cover Medicaid expansion hovers closer to $2.5 billion over ten years – nearly half of the Governor's purported price tag.[12]

Assuming Deal is correct, and assuming Georgia only collects half of the predicted federal funds, Georgia would have collected over $19 billion dollars through the year 2022. Accordingly, Medicaid expansion in Georgia would not only increase federal funding, it would result in the coverage of nearly 650,000 low-income residents. Additionally, data from eleven expansion states-Arkansas, California, Colorado, Kentucky, Michigan, New Mexico, Oregon, Maryland, Pennsylvania, Washington State, and West Virginia- suggests that Georgia would also enjoy cascading financial benefits that would stabilize rural hospitals and promote job growth.[13] Statistics show that rural hospitals in non-expansion states – such as Georgia – are nearly twice as likely to close.[14] Georgia, in particular, suffers from poor rural hospital health as five rural hospitals have closed since 2010.[15] Even GOP legislators opposing Medicaid expansion recognize rural health care as one of Georgia's most pressing issues.[16]

Interestingly, a growing number of Republican governors have supported expansion. In fact, Michigan, Ohio, and Indiana are among the Red States that have already expanded Medicaid.[17] Further, in spite of newly-elected Republican Governor Matt Bevin's desire to reverse Medicaid expansion,[18] Kentucky, one of the poorest states in the country has expanded, and is expected to add 40,000 jobs and $30 billion to Kentucky's economy through 2021.[19]

Expansion states saw a 26 percent reduction in uncompensated care costs in 2014, as compared to a 16 percent reduction in non-expansion states.[20] For example, Maryland reduced uncompensated care costs to hospitals by over $13.5 million in 2015 because hospitals treated fewer uninsured patients.[21] Further, expansion states enjoyed 33 percent higher job growth than non-expansion states in 2014.[22] Research from Georgia State University health policy experts suggest that Medicaid expansion would generate over 70,000 jobs statewide, adding $8.2 billion to the state's economic output, and generating increased tax revenue around $276.5 million annually.[23] Specifically, Georgia's Medicaid expansion would generate health care-related jobs (for private hospitals, private practitioners, and home health care services) and outside the health care sector (in industries such as real estate, food services, and transportation).[24] Additionally, and perhaps surprisingly, many states are beginning to understand the unintended effect Medicaid expansion has on reducing recidivism, while also reducing criminal justice spending and associated costs with health treatment during and after release from prison.[25]

Georgia's Options for Expansion

Assuming Georgia's lawmakers decide to expand Medicaid, what would expansion look like? The first and perhaps most direct approach would be to expand Medicaid as envisioned by the ACA and administered directly through the Centers for Medicare and Medicaid Services (CMS). Under this traditional approach, chosen by all but seven expansion states, CMS will delay distribution of federal funding until all newly eligible adults, up to 138 percent of the Federal Poverty Level (FPL), are covered.[26] Unfortunately, this path seems unlikely given Georgia's political climate and hostility towards President Obama.[27]

The second alternative to expand Medicaid would be with the stroke of the governor's pen through an executive order, similar to the approach taken in the state of Louisiana.[28] In fact, Georgia ranks among states with the most executive orders issued from 2009 through 2013.[29] However, despite this fact, this pathway to expansion also seems unlikely. Although Deal was previously authorized to take such action,[30] H.B. 990 requires a majority vote from the legislature before expanding Medicaid through the ACA, which essentially bars any Georgia governor from acting unilaterally.[31]

The third and most likely pathway to providing health coverage to roughly 650,000 Georgians would be to follow in the footsteps of Arkansas and six other states by expanding Medicaid using a Section 1115 waiver.[32] This process provides a greater deal of flexibility because Georgia can create a program tailor-made for and unique to Georgia's needs.[33] Through the waiver, Georgia residents could purchase private health insurance on the exchange, while paying small amounts in monthly premiums.[34] Moreover, this pathway would be most politically-palatable to Republicans as it promotes conservative ideals of private enterprise and market competition.[35] Finally, this approach offers greater independence for Georgia as there are no prohibitions stopping the governor and lawmakers from trying Medicaid expansion for a period of time with a reconsideration period to follow.[36]

The united front of Georgia lawmakers who once opposed Medicaid expansion seems to have yielded to the harsh realities of the state's health care system. For example, Health and Human Services Chair, Sen. Renee Unterman (R-Buford), recently suggested her Republican colleagues open a dialogue to present a plan to Deal that would expand access to care to hundreds of thousands of Georgians.[37] Georgia's doctors on the 7,000-member Medical Association of Georgia have similarly urged the governor to use the Section 1115 waiver.[38] Additionally, Grady Memorial Hospital – one of the nation's largest public safety-net hospitals[39] – is leading the charge alongside rural hospitals and health care facilities in Georgia to pursue the Section 1115 waiver.[40] While Governor Deal refers to this approach as an "experiment," rather than "expansion," even he concedes that it offers the greatest flexibility necessary to cover more people.[41]

Conclusion

Medicaid has historically been a program aimed at providing affordable health care to the most deserving members of our society. However, since the Supreme Court's *NFIB* decision, lawmakers in Georgia and other declining states still argue the cost is too burdensome. Notwithstanding this argument, it is clear that Georgia will benefit from closing the Medicaid coverage gap. Data from expansion states indicate that economic growth and revenue generation more than offsets any financial burden. Georgia's refusal to expand Medicaid exacerbates hospital closures, furthers job loss, and withholds access to care from almost 650,000 residents. Paradoxically, Georgia's tax dollars continue funding Medicaid in other states. Now is the time for state leaders to stop delaying and implement a flexible solution that will expand health care, create jobs, and bring over $40 billion back home to Georgia.

(Endnotes)

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2 *See* Rachel Garfield and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update*, Kaiser Fam. Found., Jan. 21, 2016, at 1.

3 *Id*. at 2.

4 *See* generally William S. Custer, *The Economic Impact of Medicaid Expansion in Georgia*, Healthcare Georgia Foundation, February 2013, at 4.o

5 *See* Editorial Board, *No Budging by Virginia Republicans on Medicaid Expansion*, The Washington Post, Dec.19, 2015 at 1 (explaining that Virginia's Democratic governor proposed a plan blocked by Republican legislators that would cover 400,000 Virginians and buttress struggling state hospitals).

6 *See* Peter Sullivan, *Alabama Latest State 'Looking' at Medicaid Expansion*, The Washington Post, Dec. 19, 2015 at 1. (noting that Alabama's Republican governor is "concerned about the plight of the working poor" and doctors losing money by practicing in rural areas).

7 *See* Jim Galloway, *Obamacare and Red-State Reality: First Signs of a Negotiated Truce*, AJC.com, Nov. 21, 2015, at 2 (observing that such a solution must be both "financially sustainable and politically digestible" in Georgia, which has vilified the ACA since 2009).

8 *See* Misty Williams, *Medicaid Expansion Critical, Hospitals and MDs Say*, Georgia Budget and Policy Institute, Oct. 31, 2013, at 2.

9 *Id*; see also Maggie Lee, *State GOP Leaders Double Down Against Medicaid Expansion*, Macon.com, Feb. 15, 2014, at 1 (noting Gov. Deal later saying that expansion would cost Georgia $4.5 billion during the same period).

10 *See generally* Bobby Jindal, *Gov. Bobby Jindal: Why I Opposed Medicaid Expansion*, NOLA.com, Jul. 23, 2013, at 2 (stating in an op-ed column that Medicaid "could" cost Louisianans $1.7 billion over the first ten years).

11 *See* Stan Dorn, Megan McGrath, and John Holahan, *What is the Result of States Not Expanding Medicaid?*, The Urban Institute, Aug. 2014, at 1 (explaining that for every $1 a state invests in Medicaid, $13.41 in federal funds flow into the state).

12 *Id*. at 3 (noting that Georgia's cost would be $254 million annually from 2013 – 2022).

13 *See* Deborah Bachrach, Patricia Boozang, Avi Herring, and Dori Glanz Reyneri, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, Robert Wood Johnson Foundation, Mar. 2016, at 3.

14 *Id*. at 2 (basing measurements on financial strength, population risk, and quality outcomes).

15 *See* Ayla Ellison, *A State-by State Breakdown of 57 Rural Hospital Closure*s, Becker's Hospital CFO, available at http://www.beckershospitalreview.com/finance/a-state-by-state-breakdown-of-57-rural-hospital-closures.html (last visited Jul. 26, 2016); *See also* Galloway, *supra* note 7, at 1 (noting that Hutcheson Medical Center – the most recent closure – in Ft. Oglethorpe once employed 900 with an annual payroll of $29 million).

16 *See* Andy Miller, *Suburban Lawmaker Champions Cause of Rural Hospitals in Georgia*, Georgia Health News, Feb. 11, 2016, at 1 (noting that State Rep. Geoff Duncan (R-Cumming) sponsored H.B. 919 allowing "individuals and corporations to get a state tax credit for donating money to rural health organizations").

17 *See* Editorial Board, *Medicaid Expansion in Red States*, The New York Times, Mar. 16, 2015, at 2.

18 *See* Ashley Lopez, *Kentucky's New Governor Could Roll Back Medicaid, Even as State Benefits*, NPR.org, Dec. 8, 2015.

19 *See* Kerri Richardson and Terry Sebastian, *KY's Medicaid Expansion: 40,000 Jobs, $30B Economic Impact*, Kentucky.gov, Feb. 12, 2015.

20 *See Deborah Bachrach, Patricia Boozang, Avi Herring, and Dori Glanz Reyneri, States Expanding Medicaid See Significant Budget Savings and Revenue Gains, Robert Wood Johnson Foundation, Mar. 2016, at 2 (noting that expanding Medicaid drove down uncompensated care nationally by $7.4 billion in 2015).*

21 *Id*. at 5.

22 *See* Bachrach, *supra* note 16, at 2.

23 *See* Custer, *supra* note 4, at 4.

24 *Id*. at 5 (noting that over half of the jobs created by Medicaid expansion would be in the health care industry).

25 *See generally* Jocelyn Guyer, Deborah Bachrach, and Naomi Shine, *Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Towards Opportunities for States*, Robert Wood Johnson Foundation, Nov. 2015 (noting that Ohio's expansion saved $10.3 million to cover inmates' inpatient care in 2014).

26 *See* Robin Rudowitz and MaryBeth Musumeci, *The ACA and Medicaid Expansion Waivers*, Kaiser Fam. Found., *available at* http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/ (last visited Jul. 27, 2016).

27 *See* Galloway, *supra* note 7, at 2.

28 *See* Richard Fausset and Abby Goodnough, *Louisiana's New Governor Signs an Order to Expand Medicaid*, The New York Times, Jan. 12, 2017, at 1 (stating that Mr. Edwards seeks to fulfill his campaign promise to expand health care to hundreds of thousands).

29 *See* Joy Wang, *The Case of the Missing Executive Orders: (A Lack of) Transparency in Georgia's Government*, Sunlight Foundation, Aug. 6, 2014, at 2 (noting that Gov. Deal issued 600 executive orders in 2013 and over 200 during the first half of 2014).

30 *See* Ga. Const. art. III, § IX, para. IV(a) (noting that the governor can proclaim a "major catastrophe" where funds can be utilized for relief purposes).

31 *See* Misty Williams, *Georgia Governor Basically Kills Medicaid Expansion*, Governing.com, *available at* http://www.governing.com/news/headlines/georgia-governor-basically-kills-medicaid-expansion.html (last visited Jul. 27, 2016) (noting that GOP legislators introduced H.B. 990 during the 2013-2014 session to ensure that even if a Democrat is elected governor, he or she could not expand Medicaid without legislative approval).

32 *See Current Status of State Medicaid Expansion Decisions*, Kaiser Fam. Found., *available at* http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/ (last visited Jul. 27, 2016) (indicating that Iowa, Indiana, Michigan, Montana, and New Hampshire have also approved Section 1115 waivers as of Jul. 7, 2016).

33 *See* Rachel Sachs, *Medicaid Expansion Through Section 1115 Waivers: Evaluating the Tradeoffs*, Health Affairs Blog, *available at* http://healthaffairs.org/blog/2016/03/15/medicaid-expansion-through-section-1115-waivers-evaluating-the-tradeoffs/ (last visited Jul. 27, 2016).

34 *Id*. at 2 (arguing that this fosters positive social developments by creating solidarity among Medicaid-eligible and wealthier populations alike).

35 *See* Jane B. Wishner, John Holahan, Divvy Upadhyay, and Megan McGrath, *Medicaid Expansion, the Private Option, and Personal Responsibility Requirements: The Use of Section 1115 Waivers to Implement Medicaid Expansion Under the ACA*, The Urban Institute, May 2015, at 5.

36 *See* Rudowitz, et al., *supra* note 26, at 3 (noting that there is no deadline for states to consider waivers or modify the expansion).

37 *See* Kathleen Foody, *Medicaid Expansion Remains Divisive for Georgia Republicans*, AJC.com, Jun 11, 2016, at 1.

38 *See* Williams, *supra* note 8, at 1

39 *See* Phil Galewitz, *Economy Boosts Safety-Net Hospitals in States Not Expanding Medicaid*, The Washington Post, Mar. 1, 2015, at 2.

40 *See* Greg Blustein, *Nathan Deal on Medicaid Waiver: More Would be Insured, But it's Still Not an Expansion*, AJC.com, May 8, 2015, at 1.

41 *Id*. at 2.

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